Application for Retirement Benefits – Part 1

State Form 23226 (R19/11-00)
Approved by State Board of Accounts **2000**

Indiana State Teachers' Retirement Fund
150 West Market Street, Suite 300
Indianapolis, IN 46204-2809
Telephone: (317) 232-3860 / (888) 286-3544

NOTE: The following forms are **mandatory** and must be submitted with this application:

1. **Proof of Birth** for the applicant and the co-survivor (if applicable)
2. **Application for Direct Deposit**
3. **Substitute Federal Tax Withholding Form**

The following form is **optional** and may be submitted with your application:

1. Form for Monthly State Tax Withholding OR
   Form for One Time Lump Sum State Tax Withholding

PRIVACY NOTICE

Your Social Security number is requested by this agency pursuant to the requirements of Internal Revenue Code 3405. Disclosure is mandatory; this form will not be processed without this information.

WHEN COMPLETED, YOU MUST SUBMIT ALL SIX PAGES OF THIS RETIREMENT APPLICATION.

TYPE OF RETIREMENT				
1. Is this a **regular** retirement?	**YES**		**NO**	
2. Is this a **disability** retirement?	**YES**		**NO**	

APPLICANT INFORMATION				
3. Name of Applicant (*first, middle, last)*		4. TRF Number	5. Social Security number	
6. Current Full Address (*Street or P.O. Box, city, state, ZIP Code*)		7. Date of Birth	8. Area Code and Telephone Number ( ) -	
		9. Last Day of Work (See Instructions)		
10. Future Full Address (If Moving)	11. Anticipated Date of Move	12. Date of Delayed Retirement (See note on facing page)		
13. Please pay any retroactive benefits to which I may be entitled.		**YES**	**NO**	

SERVICE IN THE PUBLIC EMPLOYEES' RETIREMENT FUND (PERF) (PLEASE CHECK "YES" OR "NO")				
14. Are you now, or have you ever been employed by a municipality, school, or any position that required membership in the Public Employees' Retirement Fund (PERF)?		**YES**	**NO**	
Years of PERF Service (If Applicable)		Location of PERF Service (If Applicable)		
15. Are you now, or have you ever been, elected or appointed to an elected position that required membership in the Public Employees' Retirement Fund (PERF)?		**YES**	**NO**	
Years of PERF Service (If Applicable)		Location of PERF Service (If Applicable)		

**** MEMBERS MUST INITIAL THE BOTTOM OF THIS PAGE WHEN COMPLETED.***

MEMBER'S INITIALS _____

ELECTION OF PENSION BENEFIT OPTION

Select **one** of the following six options for the pension portion of your retirement benefit. The Option A-4 may be used in combination with any of the six listed options. Indicate your selection(s) by placing an "✗" or a "✓" in the box that corresponds to your choice.

☐ 16. **OPTION A-1: REGULAR FORM OF RETIREMENT**. You will receive a monthly benefit for life. If you die before receiving benefits for five years, your beneficiary will receive either your monthly benefit for the remainder of those five years or the present value of those remaining payments in a lump sum. (*Designate beneficiary selections on Page 3*)

☐ 17. **OPTION A-2: STRAIGHT LIFE WITHOUT A GUARANTEED PERIOD.** You will receive a monthly benefit for life, but there are no payments to anyone after your death.

☐ 18. **OPTION A-3: MODIFIED CASH REFUND ANNUITY** (Not available for those who elect Alternative II or IV). Like Option A-1, you will receive a monthly benefit for life. This benefit will be based on your age, salary and service (employer pension amount) and the amount of money in your annuity savings account. If you die before receiving benefits for five years, your beneficiary will receive either a monthly benefit (the employer pension amount only) for the remainder of those five years, or the present value of those remaining payments in a lump sum. Also upon your death, (whether you die before or after receiving five years of benefits) your beneficiary will receive a single payment of the amount remaining in your annuity savings account. Please note your annuity savings account balance is reduced with each monthly benefit paid. Thus, if you die after the account has been reduced to zero, there will be no annuity savings account distribution to your beneficiary. (*Designate beneficiary selections on Page 3*)

☐ 19. **OPTION B-1: 100% SURVIVORSHIP.** You will be paid a monthly benefit for life. After your death, the same monthly benefit will be paid to your co-survivor for their life. (*Designate one co-survivor on Page 3*)

☐ 20. **OPTION B-2: 66 2/3% SURVIVORSHIP.** You will be paid a monthly benefit for life. After your death, a monthly benefit in the amount of two-thirds of your benefit will be paid to your co-survivor for their life. (*Designate one co-survivor on Page 3*)

☐ 21. **OPTION B-3: 50% SURVIVORSHIP.** You will be paid a monthly benefit for life. After your death, a monthly benefit in the amount of one-half of your benefit will be paid to your co-survivor for their life. (*Designate one co-survivor on Page 3*)

☐ 22. **OPTION A-4: SOCIAL SECURITY INTEGRATION.** If you retire between the ages of 50 and 62, you may select this option and integrate your Fund benefit with your Social Security benefit. The Fund will pay you a larger monthly benefit before age 62. ***However, at age 62, your benefit will automatically reduce or be terminated depending on your estimated monthly benefit at age 62 from Social Security. This will occur whether or not you apply for Social Security benefits at age 62. You must submit a current copy of your estimated Social Security benefits for age 62. (See note on Page D)***

- **YOU MAY SELECT THIS OPTION WITH ANY OF THE ABOVE-LISTED OPTIONS BY CHECKING THE BOX.**

**** MEMBERS MUST INITIAL THE BOTTOM OF THIS PAGE WHEN COMPLETED.***

MEMBER'S INITIALS _____

CO-SURVIVOR DESIGNATION: **IF YOU HAVE SELECTED ANY OF THE "B" OPTIONS, YOU MUST DESIGNATE ONE CO-SURVIVOR IN THE SPACE THAT FOLLOWS AND PROVIDE A COPY OF THE CO-SURVIVOR'S BIRTH CERTIFICATE. YOU CANNOT CHANGE YOUR CO-SURVIVOR ONCE WE HAVE RECEIVED YOUR APPLICATION. IF YOUR CO-SURVIVOR DIES BEFORE YOU, CONTACT THE FUND FOR ADDITIONAL INFORMATION.**

23. Name of Co-Survivor	24. Date of Birth	25. Relationship
26. Full Address (*Street or P.O. Box, city, state, ZIP code*)	27. Social Security number	
	28. TRF Number (*If the co-survivor is also a member of the Fund*)	

BENEFICIARY DESIGNATION

This section should only be completed if you chose an "A" Option on Page 2. If you want any lump sum payment that might be due at your death to go to specific beneficiaries, rather than to your estate, select beneficiaries below.

29. Name of Beneficiary #1	Primary ☐ Secondary ☐	Full Address of Beneficiary #1 (*Street or P.O. Box, city, state, ZIP Code*)
Date of Birth / Relationship / Social Security number		

30. Name of Beneficiary #2	Primary ☐ Secondary ☐	Full Address of Beneficiary #2 (*Street or P.O. Box, city, state, ZIP Code*)
Date of Birth / Relationship / Social Security number		

31. Name of Beneficiary #3	Primary ☐ Secondary ☐	Full Address of Beneficiary #3 (*Street or P.O. Box, city, state, ZIP Code*)
Date of Birth / Relationship / Social Security number		

32. Name of Beneficiary #4	Primary ☐ Secondary ☐	Full Address of Beneficiary #4 (*Street or P.O. Box, city, state, ZIP Code*)
Date of Birth / Relationship / Social Security number		

**** MEMBERS MUST INITIAL THE BOTTOM OF THIS PAGE WHEN COMPLETED.***

MEMBER'S INITIALS _____

ELECTION FOR ANNUITY SAVINGS ACCOUNT PAYMENT

You must select **one** of the seven alternatives described below. You may only select one of the options. **This selection cannot be changed by the Fund once the application has been received.**

☐ 33. **ALTERNATIVE I**. I elect to receive the total amount of my Annuity Savings Account paid as a monthly benefit. I understand that I will not receive any distribution from my Annuity Savings Account other than this monthly benefit.

☐ 34. **ALTERNATIVE II-A**. I elect to have the total amount of my Annuity Savings Account (less the mandatory withholding for federal income tax) ***paid directly to me.*** *(See Pages J - O)*

☐ 35. **ALTERNATIVE II-B**. I elect to have **ALL** of the taxable portion of my Annuity Savings Account paid in the form of a direct rollover to an Individual Retirement Account or a Qualified Retirement Plan that has provisions allowing it to accept the rollover on my behalf. The non-taxable portion will be ***paid directly to me***. (See Box 40 below) *(See Pages J – O)*

☐ 36. **ALTERNATIVE II-C**. (*May be selected only if you want a partial rollover amount of at least $500.*) I elect to have a part of the taxable portion of my Annuity Savings Account paid in the form of a direct rollover to an Individual Retirement Account or a Qualified Retirement Plan that has provisions allowing it to accept the rollover on my behalf. The non-taxable portion will be ***paid directly to me***. Also, the "part" of the taxable portion of the distribution that is not directly rolled over (less the mandatory withholding for federal income tax) will be ***paid directly to me***. (See Box 40 below) *(See Pages J – O)*

PARTIAL ROLLOVER AMOUNT *(Must be at least $500)* **$** _____

☐ 37. **ALTERNATIVE III**. I elect to receive a distribution of an amount equal to my tax basis (after-tax contribution) in my Annuity Savings Account balance as it existed on December 31, 1986 and receive the balance of the account as a monthly benefit.

☐ 38. **ALTERNATIVE IV-A**. I elect to defer distribution of my Annuity Savings Account ***until a later date***. My account will continue to be invested with the Fund under the same guidelines applicable to an Annuity Savings Account. I understand that I may make changes to the allocation strategy of my Annuity Savings Account quarterly.

☐ 39. **ALTERNATIVE IV-B**. I elect to receive a distribution of an amount equal to my tax basis (after-tax contribution) in my Annuity Savings Account balance as it existed on December 31, 1986 and defer distribution of the remainder of my Annuity Savings Account ***until a later date***. My account will continue to be invested with the Fund under the same guidelines applicable to an Annuity Savings Account. I understand that changes to the allocation strategy of my Annuity Savings Account may be made quarterly.

BENEFICIARY FOR ALTERNATIVES IV-A & IV-B This beneficiary designation is for the Annuity Savings Account only and is applicable only if an Alternative IV is selected by the member. If you select Alternative IV-A or IV-B, you may designate beneficiary(ies) on Page 5.

40. **IDENTIFICATION INFORMATION OF INDIVIDUAL RETIREMENT ACCOUNT OR QUALIFIED RETIREMENT PLAN**.

I represent that the designated plan is an Individual Retirement Account or Qualified Retirement Plan that has provisions allowing it to accept direct rollovers on my behalf. The Fund should make the direct rollover check for the amount shown above payable to:

_____ as trustee of _____

Name of IRA Company *Member's Name*

My Individual Retirement Account number is _____. (If Applicable)

**** MEMBERS MUST INITIAL THE BOTTOM OF THIS PAGE WHEN COMPLETED.***

MEMBER'S INITIALS _____

ALTERNATIVE IV BENEFICIARY DESIGNATION

PLEASE ONLY COMPLETE THIS PAGE IF YOU HAVE CHOSEN ALTERNATIVE IV-A OR IV-B ON PAGE 4 OF 6.

If you want the annuity savings account balance due at your death from Alternative IV-A or IV-B to go to specific beneficiaries, rather than to your estate, select beneficiaries below.

41. Name of Beneficiary #1			Primary ☐ Secondary ☐	Full Address of Beneficiary #1 (*Street or P.O. Box, city, state, ZIP Code*)
Date of Birth	Relationship	Social Security number		
42. Name of Beneficiary #2			Primary ☐ Secondary ☐	Full Address of Beneficiary #2 (*Street or P.O. Box, city, state, ZIP Code*)
Date of Birth	Relationship	Social Security number		
43. Name of Beneficiary #3			Primary ☐ Secondary ☐	Full Address of Beneficiary #3 (*Street or P.O. Box, city, state, ZIP Code*)
Date of Birth	Relationship	Social Security number		
44. Name of Beneficiary #4			Primary ☐ Secondary ☐	Full Address of Beneficiary #4 (*Street or P.O. Box, city, state, ZIP Code*)
Date of Birth	Relationship	Social Security number		

MEMBERS MUST INITIAL THE BOTTOM OF THIS PAGE WHEN COMPLETED.
(The Member's initials are required even if this form is left blank.)

MEMBER'S INITIALS _____

AFFIRMATION

I affirm that I am the above named applicant; that I have personally prepared the aforegoing application; and that I have carefully read the questions and answers thereto and understand the same; that each is full, complete and true; no material fact has been concealed or omitted therefrom; and that said answers are made for presentation to the Board of Trustees of the Indiana State Teachers' Retirement Fund in making claim for a retirement benefit that may be payable to me pursuant to Indiana Code, section 5-10.2 and section 21-6.1.

45. Signature of Member		46. Member's Full Address (*Street or P.O. Box, city, state, ZIP Code*)
47. Printed Name of Member	48. Date Signed	

NOTARY PUBLIC CERTIFICATION

STATE OF _____ }
COUNTY OF _____ } ss:

EMBOSS HERE

This voluntary act sworn to before me, a Notary Public, in and for said State and County,

this _____ day of _____ , 20 _____.

49. Notary Public Signature	50. Notary Public Printed Name (REQUIRED)	51. Date Commission Expires

NOTE: If the above is being signed by an Attorney-in-Fact or Legal Guardian, copies of the corresponding Power of Attorney or Guardianship of the Person must accompany this application.

Once completed, please mail this application as soon as possible to:

Indiana State Teachers' Retirement Fund
150 West Market Street, Suite 300
Indianapolis, IN 46204-2809

**** MEMBERS MUST INITIAL THE BOTTOM OF THIS PAGE WHEN COMPLETED***.

MEMBER'S INITIALS _____

THIS FORM IS REQUIRED TO COMPLETE THE RETIREMENT PROCESS.

APPLICATION FOR DIRECT DEPOSIT

State Form 47144 (R3 / 01-02)
Approved by State Board of Accounts 2002

INDIANA STATE TEACHERS' RETIREMENT FUND
150 West Market Street, Suite 300
Indianapolis, Indiana 46204-2809
(888) 286-3544 / www.in.gov/trf

A trust is deemed to be in effect by the operation of this instrument in the periodic transfer of funds by the payor to the financial organization acting as trustee for the lifetime benefit of the payee to retain and to revert to the payor the funds transferred after the death of the payee. This instrument is governed by the Indiana law and enforceable under the jurisdiction of the State of Indiana. Social Security numbers are requested by this state agency in accordance with the requirements of IRS Code 3405. This form will not be processed without this information.

READ INSTRUCTIONS ON BACK. TYPE OR PRINT

PART 1 - AUTHORIZATION

Instead of receiving periodic recurring benefit payments by check from the Indiana State Teachers' Retirement Fund, I (*payee*) authorize and request TRF to direct the net amount of such recurring payments to my account at the financial organization (*Bank*) designated below, and I authorize said Bank to accept and to credit the payments to my account. I acknowledge that the transfer of the payments by TRF to the Bank be deemed complete satisfaction and discharge of the obligation of TRF due me. This authorization is not an assignment of my right to receive payment and revokes all prior payment direction notifications applicable to these payments. I will comply with the Bank's procedures providing safeguards against withdrawals of deposits after my death. If any deposits are made subsequent to my death to which I am not entitled, I hereby authorize and direct said Bank on behalf of my estate to refund said deposits to TRF and to charge same to my account.

Name of payee	TRF account number	Social Security Number

Address (number and street)	City	State	Zip Code	Telephone number

Are you receiving more than one monthly benefit check from TRF?	If so, do you wish to have all TRF accounts electronically deposited?	If so, do you want all TRF checks deposited into the same account?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Signature of payee	Date signed

PART II – REPAYMENT ACKNOWLEDGEMENT

This section must be completed by any person other than the payee who will or may have access to the account into which the TRF benefit will be deposited, such as including but not limited to a person designated a power of attorney, a guardian or conservator, or a joint owner of the account. All such persons who have such access do hereby agree, as evidenced by their signatures, to notify the Bank and TRF of the payee's death promptly and further agree to be held liable for any amounts due to be returned to TRF from the deposit account after the payee's death.

NAME OF AUTHORIZED PERSON	PERSON'S SIGNATURE	DATE SIGNED	SOCIAL SECURITY NUMBER

PART III – ENDORSEMENT (*Financial Organization Must Complete This Section)*

We, the Bank, hereby agree to accept the authorization hereinabove conferred. We acknowledge that the authorization is not a power of attorney or agency within the meaning of Indiana Code 30-5-1-1 et seq., and that the death of the payee terminates the Bank's authority to accept payments from TRF, and to credit the amount to the payee's account. We understand that our account number, shown for the payee named herein, will be included on individual payment credits to his / her account. The terms which protect the rights and interests of a federal agency payor, as contained in 31 CFR parts 240, 209, and 210, shall be applicable in the operation of this agreement; and we further agree, upon acquiring knowledge of the death of the payee, to refund to TRF all deposits received subsequent to death.

Routing number (ABA Number) ☐☐☐☐ — ☐☐☐☐☐	Name and address of Financial Organization	
Type of deposit or account ☐ Savings ☐ Checking		
Deposit account number		
Deposit account title *(All names on the account)*	Authorized signature of Financial Organization Officer	Date signed
Branch name / Telephone number	Printed name of Financial Organization Officer	Title of officer

PLEASE BE SURE YOU HAVE READ THE INSTRUCTIONS ON THE BACK.

INSTRUCTIONS FOR COMPLETING DIRECT DEPOSIT FORM

1. *Your Social Security number must be entered in Section I. If you are a survivor entitled to receive the original member's benefit, enter YOUR Social Security number, not that of the deceased.*

2. *The DEPOSIT ACCOUNT TITLE in Section III MUST contain the NAME(S) (all of them) that are on the account, NOT the type of account.*

3. *Your financial institution MUST complete Section III BEFORE returning the form to our office. A financial officer MUST sign and date the form in Section III.*

4. *This form must be in our office no later than the 5th of the month for your direct deposit to begin on the 1st of the following month. For example, if you want your direct deposit to begin on October 1, we must have the completed form in our office by September 5.*

5. *If the account is a joint account, any other person(s) on the account MUST complete Section II.*

6. *This form must be signed by the payee or the payee's duly authorized and appointed power of attorney or guardian / conservator. If the form is signed by the holder of a power of attorney or guardian / conservator rather than the member, a copy of supporting documents MUST be attached to the direct deposit form when returned for processing. The person signing MUST complete Section II.*

NOTE: YOU WILL ALSO RECEIVE AN ELECTRONIC FUND TRANSFER RECEIPT IN THE MAIL EACH MONTH SIMILAR TO A CHECK STUB. THIS RECEIPT WILL VERIFY THE MONTHLY ELECTRONIC DEPOSIT BY TRF.

THIS FORM IS MANDATORY AND MUST BE SUBMITTED WITH YOUR RETIREMENT APPLICATION

Substitute Federal Tax Withholding Form

(For Fixed Monthly Amount)

Member's Full Name *(Type or Print)*		Member's Social Security Number	
Member's Full Address *(Number and street or rural route)*		Member's TRF Number	
City	State	ZIP Code	Member's Phone Number ( ) -
I authorize the Indiana State Teachers' Retirement Fund to withhold the following dollar amount **each month** as federal tax withholding: **$**			
Member's Signature		Date of Member's Signature	

This form is required for retirement processing.

Should you have any questions regarding the tax status of your retirement, please consult a qualified tax professional.

IF YOU WOULD LIKE TO HAVE INDIANA STATE TAX WITHHELD, PLEASE COMPLETE THIS FORM.

The Indiana State Income Tax rate is 3.4%

State of Indiana

Annuitant's Request for State Income Tax Withholding

FORM WH-4P Revised 9/90

Type or Print Full Name		**Social Security Number**
Home Address (Number and street)		
City	**State**	**ZIP Code**
Annuity Contract Claim Number or Identification Number (TRF Number)		
Enter the amount to be withheld each month from annuity or pension payment.		**$**
I hereby request voluntary State Income Tax withholding from my annuity or pension payments.		
Signature of Annuitant	**Date**	

IF YOU CHOOSE TO RECEIVE A LUMP SUM PAYMENT OF YOUR ANNUITY SAVINGS ACCOUNT AND WOULD LIKE TO HAVE INDIANA STATE TAX WITHHELD, PLEASE COMPLETE THIS FORM.

State of Indiana

Annuitant's Request for State Income Tax Withholding

FORM WH-4P Revised 9/90

Type or Print Full Name		**Social Security Number**
Home Address (Number and street)		
City	**State**	**ZIP Code**
Annuity Contract Claim Number or Identification Number (TRF Number)		
Enter the amount to be withheld from your lump sum payment.		**$**
I hereby request voluntary State Income Tax withholding from my annuity or pension payments.		
Signature of Annuitant	**Date**	